

Painting by numbers

With the heroin-crack using population getting older and a younger population hooked on a mix of alcohol, cannabis and cocaine, the importance of local needs assessments in plotting change has never been greater. By **Howard Parker**

Each drug and alcohol action team (DAAT) in England is now required by the NTA to develop a local needs assessment system, first for adults and shortly to include young people. Goals include identifying unmet need and hidden drug-using populations – thus having a local evidence base to help commission and reconfigure services and interventions. This is a much-needed requirement, because the official focus remains dominated and blinkered by the heroin-crack-crime reduction agenda. The newest NTA guidance of July 2007 is both prescriptive and demanding. What it lacks is any notion of changing substance use trends and thus any ‘out of the box’ thinking about future service provision requirements.

Undoubtedly the management of the classic heroin-crack user will remain critical, especially in ‘second wave’ areas where heroin only bedded-in during the 1990s and was quickly followed by crack. Here, the classic poly drug-using population must remain a management priority.

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However, all the indicators are pointing to the development of a post-heroin population of younger substance users, who have problems with binge drinking, regular use of strong skunk and cocaine. Ecstasy and in some areas amphetamine are also part of the possible repertoire. More potentially complex presentations involve a mixture of all the above. This is why DAATs should set the NTA approach within a broader definition of unmet need and not closed down by drugs politics.

A potentially effective approach to developing a local monitoring model is to create an internally managed ‘intelligent’ system, led by core stakeholders and managed by a data analyst. Below are examples of how to set up needs

assessment systems in five services, all of which, along with other types of services, will feed into the building of a drug use profile and therefore identify unmet need in local areas (see diagram opposite).

● Needle exchange schemes

There is a tension between providing a confidential exchange service and collecting critical data. In practice, areas that are collecting information such as date of birth and asking questions such as ‘which drugs are you using?’ and ‘have you been in treatment?’ find customers are not put off. Such data allows us to ethically cross-check with the National Drug Treatment Monitoring System (NDTMS) on treatment status to identify those with unmet treatment need and to signpost them into treatment. Some DAAT areas are identifying large numbers of people at needle exchanges who should be in treatment, including many heroin-crack speed-balling injectors. Importantly, a younger steroid-only population is being identified in many areas.

● Young people’s tier two and three services

The alcohol-cocaine-cannabis-ecstasy (ACCE) profile now dominates presentations to under-18s services in most areas, not least because alcohol referrals are routinely accepted. Undertaking needs assessments for young people is very complex. But as a first step much intelligence can be gleaned from secondary analysis of case summaries, stakeholder perceptions and scanning alcohol and drug users known to the youth offending teams, Connexions, leaving care teams and pupil referral units. Tier two workers such as youth workers and school nurses need bringing into the provision as key players who receive training, a validated screening tool and direct access to specialist drug workers. Those who work with young people regularly hear talk about new drug fashions and are often first to identify changing consumption trends. As the Children’s Trusts agenda rolls out, the importance of identifying and referring young people with substance issues must remain paramount. Lifestyle surveys among pupils at schools and colleges can also provide important evidence, while internal communication between departments about research and surveys is vital.

● **Community alcohol service and poly-substance profiles**
 Currently too many adult alcohol services remain preoccupied with treating middle age problem drinkers, those most commonly referred by primary health workers. This is because they are busy, seriously under-resourced and so find it hard to reach out to other problem alcohol users in the community. Is this why they may not be seeing younger presenters? Is there evidence from criminal justice workers that the young adult alcohol-cocaine user is 'out there' being identified via assault or domestic violence offences? Can resources be found to make services accessible and attractive to younger people? Are services screening for drugs and poly substance use?

If evidence builds that there is likely unmet need, the case for piloting specialist workers competent to deal with alcohol and drug cases is made. The pilot in turn provides further evidence. Some areas in north-west England are now responding to the clear presence of the ACCERs and their drop out rather than transfer to the adult 'smackhead' services at 18-19 years by creating young adult transitional services or even merging their alcohol and drug services. Needs assessment is led by questions such as: are we seeing these changing substance trends and related problems locally? Is the image of the service and its accessibility blocking more presentations from non-heroin users?

● **Criminal justice agency profiles**

Much can be gleaned from data available from probation, the drug interventions programme (DIP) and prolific offenders about any changing trends or potential unmet need. High intensity DIPs with mandatory drug testing and required assessments have a treasure trove of intelligent data. In many 'first wave' heroin areas clear evidence is emerging that heroin-crack users are getting older. Few twenty-somethings test positive for opiates, yet up to 40 per cent of cocaine positives are in fact young powder cocaine users. DIP records can be analysed to profile these two populations in respect of age, geography, crime-causing status, treatment experience, unmet need or rejection of treatment entry. Nevertheless, here is robust evidence of the emergent cocaine-alcohol user. Do we require a 'voluntary' service or support groups for some of these users? Is there emergent evidence of increasing problems with use and dependency to help plan future provision?

● **Hospital Admissions: A&E**

Accessed via good negotiating skills, patience and tenacity, hospital data is a very useful tool. Reasons for admission and diagnosis codes can all build a picture of the extent of local drug use. A&E departments are critical in terms of

identifying unmet and emergent need, early interventions and trends data. Because it is hard to make a business case for an alcohol-drug liaison nurse attached to a tier three service – given the state of hospital databases – sometimes needs assessments are best developed through pilot provision.

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Where DAATs and primary care trusts have paid for A&E liaison workers, we usually find plenty of referrals that would otherwise not have been identified. For instance, young people's services see significant numbers of teenagers who've overdosed on alcohol or lost the plot by mixing substances, plus accidents and injuries related to intoxication. A competent liaison worker can not only create a fluid caseload and move cases into tier three, but also set up an internal referral system and train up A&E staff and provide brief interventions with young people and parents. This type of approach also fits the Every Child Matters agenda of safeguarding and reducing accidents and injuries. The case for adult provision can be assessed in the same way.

These five examples show how we can simultaneously develop evidence-collecting systems, fine-tune current provision and test out new service entry points. There are numerous other pieces in the jigsaw such as sex workers and dual diagnosis patients which can add colour to the local picture. Service user groups can provide important information about emergent drug markets or misuse trends. The local night-time economy can tell us plenty, from the results of police swabbing of licensed premises, amnesty box contents, to the observations of paramedics or bar staff. The possibilities are numerous and vary by area.

This system will only be successful if senior managers rise above the distorting impact of key performance indicators, targets and traffic lights and commit time for strategic, 'outside the box' thinking and endeavour to piece together local data to build a coherent picture through time. A point is then reached where a working model genuinely reflects local realities and in turn routinely informs planning and commissioning and ensures services better match local needs.

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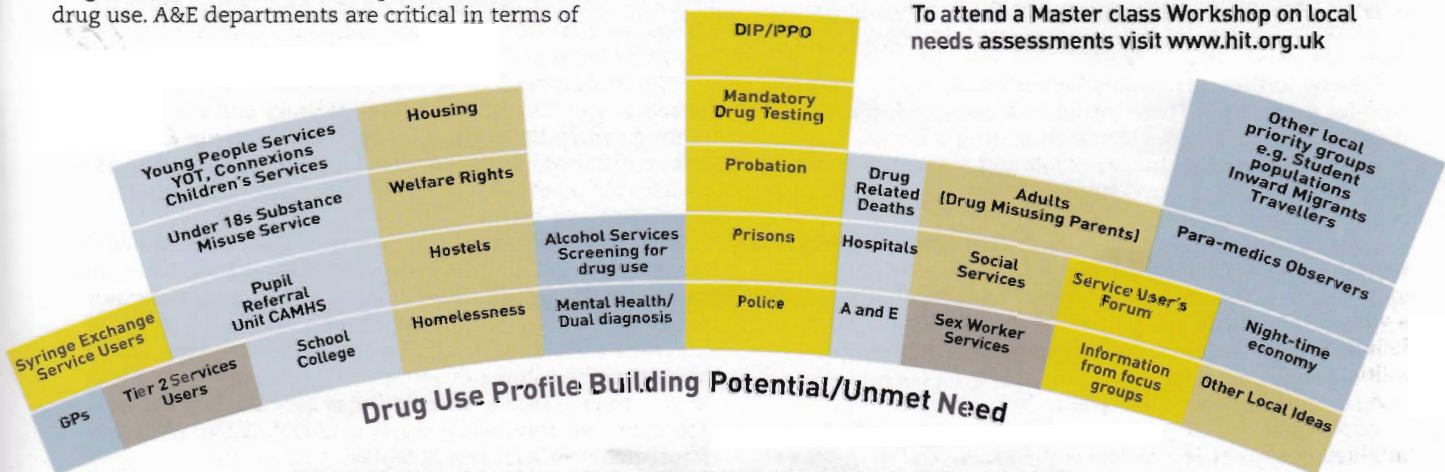


Diagram 1 – Potential Indicators for Local Needs Assessment Systems: A Jigsaw Analysis